Rural Healthcare Quality Network

Root Cause Analysis Workshops

Interactive Workshops Designed To:

- Introduce attendees to the JCAHO and VA models for conducting RCA
- Share Tools
- Have attendees work through an RCA
- Networking

Workshop Overview

- Determine when an RCA should be done
- Identify steps in the process
- Facilitate an RCA team
- Documenting the RCA activity correctly

When To Use RCA

- Sentinel event “ an unexplained occurrence involving death or serious physical or psychological injury. Or the risk thereof. (JCAHO Sentinel Event Policies and Procedures)
- National Quality Forum Adverse Event Reporting
- Anytime you are concerned about a process or outcome

Purpose of the RCA

- To answer critical questions:
  * What happened (or is happening)?
  * How did it happen?
  * How can we prevent it from happening again?
  * What can we learn from this?

The Workshop will cover Steps in the RCA process

- Protect Patients
- Charter an RCA team
- Assemble the team
- Prepare the team
- Identify what is already known
- Human Factors component

Root Causes, Actions and Outcome Measures: Make it Easy to do

- VA tools: Triage flip book “5 rules of Causation”
- Brainstorm
- Compare each Root Cause statement with the “5 Rules”

5 Rules

- Show cause and effect
- Nothing negative about people
- Fix systems, not people
- Fix “norms”, not people
- Duty to act

Examples

- Rule 1 “Clearly show the “cause and effect” relationship

WRONG: A Nurse was fatigued

CORRECT : With overtime, nurses are often scheduled more than 40 hours a week; as a result, fatigued nurses are more likely to misread tube insertion instructions

Rule 2

- Use specific and accurate descriptions of what happened, rather than negative and vague words.

  WRONG: Poorly written procedure

  CORRECT: The restraint procedure has 8 point font and no illustrations; so staff don’t use it, increasing the likelihood that restraints are applied incorrectly.

Rule 3

- Identify the preceding cause(s), not the human error

  WRONG: Staff did not notice the patient was missing for at least 8 hours.

  CORRECT: Due to a malfunction in the door/vest wandering alarm, a patient was able to leave undetected.

Rule 4

- Identify the preceding cause(s) of procedure violations.

WRONG: Week-end staff did not follow the policy for dressing changes.

CORRECT: Due to a shortage of supplies over the week-end (dressings, and cleansing solutions) dressings were not changed as frequently as policy requires

Rule 5

- Failure to act is only causal when there is a pre-existing duty to act.

WRONG: the nurse did not check for STAT orders.

CORRECT: the absence of an assignment for nurses to check for STAT orders increased the likelihood that STAT orders would be missed or delayed.

ACTIONS

- Be specific and clear
- Specifically address the root cause
- Test the actions or simulate the process changes before implementing system change
- Check with the process owners

Outcome Measures

- Be specific and quantifiable: Use numerators, denominators.
- State how many things you are going to check, and how often you're going to check

RHQN RCA Workshops

- Make it easy to do
- Explore tools and techniques that make the process easier
- Held regionally: Eastern, central, western locations.

Questions?

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References:

Helen Harte, RN, MPH, MPA
Veterans Administrations
http://www.va.gov/ncps/pubs.html
JCAHO www.jcaho.org